Agency:	**107** Health Care Authority
Decision Package Code/Title:	**PL-ER** ProviderOne Phase 2
Budget Period:	**2012 Supplemental**
Budget Level:	**PL –**Performance Level

Fiscal Detail/Objects of Expenditure

	FY 2012	FY 2013	Total
1. Operating Expenditures:			
Fund 001-1 General Fund State	$ 1,109,000	$ 1,471,000	$ 2,580,000
Fund 001-2 GF-Federal - Basic	$ -	$ -	$ -
Fund 001-C GF-Federal - Medicaid	$ 9,428,000	$ 12,462,000	$ 21,890,000
Fund 001-7 GF-Private/Local	$ -	$ -	$ -
Fund 16W-1 Hospital Safety Net	$ -	$ -	$ -
Fund 418-1 HCA Admin Account	$ -	$ -	$ -
Total	**$ 10,537,000**	**$ 13,933,000**	**$ 24,470,000**
2. Staffing:			
Total FTEs	31.0	47.0	39.0
3. Objects of Expenditure:			
A - Salaries And Wages	$ 2,392,000	$ 3,472,000	$ 5,864,000
B - Employee Benefits	$ 726,000	$ 1,074,000	$ 1,800,000
C - Personal Service Contracts	$ 1,589,000	$ 1,689,000	$ 3,278,000
E - Goods And Services	$ 5,810,000	$ 7,673,000	$ 13,483,000
G - Travel	$ 20,000	$ 25,000	$ 45,000
J - Capital Outlays	$ -	$ -	$ -
N - Grants, Benefits & Client Services	$ -	$ -	$ -
Other (specify) -	$ -	$ -	$ -
Total	**$ 10,537,000**	**$ 13,933,000**	**$ 24,470,000**
4. Revenue:			
Fund 001-2 GF-Federal - Basic	$ -	$ -	$ -
Fund 001-C GF-Federal - Medicaid	$ 9,428,000	$ 12,462,000	$ 21,890,000
Fund 001-7 GF-Private/Local	$ -	$ -	$ -
Fund 418-1 HCA Admin Account	$ -	$ -	$ -
Total	**$ 9,428,000**	**$ 12,462,000**	**$ 21,890,000**

Recommendation Summary Text

The Health Care Authority (HCA) requests a re-appropriation of $2,580,000 GF-State from FY 2011 to the 2011-13 Biennium for a portion of the FY 2011 proviso allotment to complete the implementation of ProviderOne Phase 2 along with spending authority of $21,890,000 GF-Federal and 39 FTEs in the 2012 Supplemental . This funding will ensure that $2 B in Medicaid expenditures for the Department of Social and Health Services (DSHS), Adult and Disability Services Administration (ADSA) Home and Community Service (HCS) payments can shift from the 30-year old Social Service Payment System (SSPS) to the state's new Medicaid payment system, ProviderOne. This request supports the consolidation of the state's Medicaid business into a single, modern

payment system so that a client's holistic record of Medicaid services are available for improved coordination of care through the exchange of electronic health records.

Package Description

This request is to secure the remaining funds necessary to complete ProviderOne Phase 2 to ensure $2 B in DSHS Medicaid expenditures for home and community based services can shift from the 30 year old SSPS system to ProviderOne. Included in this request are support system vendor services, consulting services and 31 FTEs (FY 2012) and 47 FTEs (FY 2013). The FTE request reflects a decrease in staffing from over 50 FTEs dedicated to the project in Phase 1. The increase in FTEs in FY 2013 is to support implementation of a pilot in advance of full statewide rollout. These additional FTEs will respond to provider telephone inquiries, administer provider and staff security, maintain the provider file, and process Phase 2 payments.

With implementation of ProviderOne Phase 1 on May 9, 2010, HCA replaced its 30-year old Medicaid Management Information System (MMIS). ProviderOne Phase 2 consolidates the remaining Medicaid programs into ProviderOne and sets the stage to replace yet another 30-year old mainframe called the SSPS. ProviderOne Phase 1 handles $5.4 B in annual Medicaid payments. Phase 2 will add another $2 B in annual Medicaid payments. ProviderOne Phase 2 qualifies for 90/10 federal financial participation (ffp) instead of the current 45/55 FFP within SSPS.

With the HCS payments consolidated from SSPS into ProviderOne, HCA will accomplish the following:

- Bring the state into compliance with federal Medicaid regulations and the Collective Bargaining Agreement (CBA) with SEIU #775;
- Obtain a higher federal match for one-time enhancements (90/10 FFP) and ongoing operations (75/25 FFP) while SSPS qualifies for 45/55 FFP;
- Give case workers access to client medical information, providing better coordination of care and potentially a higher federal match for services, and
- Increase efficiency and automation through a rules-based, highly configurable system that can respond to policy changes.

Scope

Phase 2 addresses ADSA programs currently processed in SSPS. ADSA programs include Medicaid waiver services for home and community based services for aging and developmental disabled populations. Over 40,000 providers deliver these services throughout Washington. The provider population varies from Individual Providers (IPs) represented by Service Employees International Union (SEIU) (who are subject to collective bargaining with the state), Adult Family Homes are also subject to bargaining represented by the Washington State Residential Care Council (WSRCC) , Group Homes, home care agencies and medical providers including durable medical equipment vendors, physical and occupational therapist, mental health and substance abuse counselors, psychologists and psychiatrists, dentists and nurses.

Besides a large provider component, there are significant staff and organizational readiness challenges with Phase 2. Staffs (primarily caseworkers) are located throughout the state, which

makes the staff and organizational readiness aspects even more challenging.

On the system side, the scope adds an authorization payment model to handle social service billing. This results in three payment models within ProviderOne: 1) fee for service, 2) managed care (both of which are already supported by ProviderOne), and 3) authorization based model. The social service billing model requires interfaces with the ADSA case management system (CARE) data conversion from SSPS and testing of the technical solution to ensure it functions properly in the already operational ProviderOne system.

Implementation Schedule
ProviderOne Phase 2 implementation schedule includes a three-month pilot starting in spring 2013, in a limited geographical region, followed by statewide rollout in the 2013-15 Biennium. After successful demonstration of the pilot in one region, the remaining regions will be implemented.

Questions related to the fiscal portion of this decision package should be directed to Marcia Wendling at (360) 725-1836 or Marcia.Wendling@hca.wa.gov .

Questions related to the programmatic portion of this package should be directed to Cindy Davidson, MMIS Federal Liaison, at (360) 725-1236 or Cynthia.davidson@dshs.wa.gov.

Narrative Justification and Impact Statement

ProviderOne Phase 2 has significant anticipated impacts as follows:

1. **Least costly option for meeting requirements of CMS and SEIU #775**: As the state's federally certified Medicaid system, ProviderOne qualifies for 90/10 FFP for one-time enhancements and 75/25 for on-going operations, including staffing costs. SSPS qualifies for 45/55 FFP. Continuing to invest in SSPS or investing in a new system to meet CMS and SEIU requirements for home and community services are more costly options with less federal participation.
2. **Greater administrative efficiencies by consolidating $7 B in Medicaid expenditures**: A primary goal for ProviderOne is to consolidate Medicaid payments processed by two (2) separate systems into a single payment system. This goal is supported by the federal CMS, the Joint Legislative Administrative Review Committee (JLARC), and state executives.
3. **Improved coordination of care for over 1 million needy clients and potentially higher federal match:** By consolidating client information into a single payment system, state staff will be able to coordinate care across program areas and funding sources. Besides improving the experience of clients, ProviderOne will be programmed to select the best federal match when the client is eligible for the service under more than one program/funding source.
4. **Improved payment integrity and accountability:** ProviderOne Phase 2 includes payment checks and verification not implemented today. Client eligibility, provider credentials, and payment rules (such as duplicate checks and fraud detection rules) will be validated before payment occurs, addressing many audit findings associated with home and community based services today.
5. **More flexibility to respond to evolving healthcare initiatives:** ProviderOne is a highly configurable system that allows the state to more easily make modifications to respond to policy changes at the state and federal levels.

What specific performance outcomes does the agency expect?
Expected outcomes include:

- Achieving compliance with Centers for Medicare & Medicaid Services (CMS) and CBA requirements at the lowest possible cost and a higher federal match than any other solution,
- CMS rescinds the OIG recommendation to disallow $19 M in federal program dollars,
- SEIU #775 does not pursue binding arbitration to enforce the CBA requirements,
- Improved care for clients and coordination of services,
- Increased program integrity and accountability, and
- Lower costs for ongoing maintenance to respond to policy changes.

Performance Measure Detail

Activity: H001 Administrative Costs

Is this decision package essential to implement a strategy identified in the agency's strategic plan?
Yes, ProviderOne Phase 2 supports several aspects of the strategic plan. In particular, implementation of Phase 2 supports evidence based medicine (EBM) objectives by including the full spectrum of services a client receives. Similarly, Phase 2 supports the chronic care management objective by including a broader range of services for clients. In both instances, Phase 2 expands the data used to support these two (2) objectives to include mental health, substance abuse, and community based services to name a few.

The Strategic Plan also notes that when complete, ProviderOne will:

- Support better decision making through consolidated payment data.
- Establish greater system flexibility for adapting to policy changes.
- Increase quality of client services through a more holistic approach to service delivery.
- Enhance customer service through more on-line/self-service features.
- Improve payment and cost avoidance processes through improved data integrity.

Does this decision package provide essential support to one of the Governor's priorities?
Yes. This request supports the Governor's priority: Improve the health of Washingtonians. Implementation of Phase 2 expands ProviderOne support of the Governor's healthcare initiatives by expanding services to include all Medicaid programs. By adding home and community based services to ProviderOne, the new Medicaid system will be able to support the following:

- Use evidence based medicine (across *all* programs).
- Expand chronic care management (across *all* programs).
- Emphasize health promotion and prevention (across *all* programs).
- Increase data transparency (across *all* programs).

By expanding the client services addressed in ProviderOne, the governor's healthcare priorities of government will be expanded to address home and community based services, mental health, and chemical dependency.

Does this decision package make key contributions to statewide results? Would it rate as a high priority in the Priorities of Government (POG) process?
Yes. ProviderOne Phase 2 supports the Governor's Priorities of Government (POG), especially the priority to improve the health of Washingtonians. Through greater flexibility to respond to evolving health care initiatives, improved administrative efficiencies, improved data and decision making, and expanding evidence based medicine and chronic care to address a broader spectrum of service, the next phases of ProviderOne support the governor's priorities for healthcare.

What are the other important connections or impacts related to this proposal?
By completing Phase 2, ProviderOne will realize the goals identified or endorsed early on by many stakeholder groups including CMS, JLARC, SEIU, OFM, and Information Systems Board (ISB). Additionally, Phase 2 addresses many audit findings from the State Auditor's Office (SAO) around payment integrity and accountability.

What alternatives were explored by the agency, and why was this alternative chosen?
Two alternatives were considered:

1) **Upgrade SSPS:** Upgrading SSPS to meet CMS and SEIU #775 requirements is more costly and subject to a lower federal match than investing in the state's already established Medicaid payment system – ProviderOne.
2) **Develop a new payment system:** To invest in a new payment system would require another large IT project, which would be costlier and qualify for a lower or no federal match.

Instead, decision makers chose the option of using ProviderOne to address home and community based services. Shifting SSPS programs to ProviderOne has the following benefits:

- Leverages existing technical infrastructure from Phase 1.
- Maximizes enhanced FFP for remaining Medicaid programs
- Capitalizes on the expertise of an experienced team who successfully implemented Phase 1.

To delay implementation to a future Biennium would result in:

- Missed opportunity to reverse 30 years of "siloed" data
- Increased costs long term compared to short term savings
- Lost federal revenue
- Non-compliance with federal and JLARC recommendations
- Non-compliance with audit findings
- Inability to respond to SEIU CBA requirements

What are the consequences of not funding this package?
1. CMS requests refund of enhanced match paid since January 2011

   With approval of the Phase 2 Advanced Planning Document, CMS has been paying an enhanced match for all project costs since January 2011. With no benefit being realized for Phase 2, CMS can request the federal portion of the project costs be re-paid.
2. SEIU 775 CBA articles relating to the "Modern Payroll System" are not realized

   The union has been requesting a "Modern Payroll System" since 2007 due to the difficulties SSPS has in satisfying bargained items. Phase 2 is scheduled to implement this "Modern Payroll

System" through the Provider Compensation Subsystem (PCS) of ProviderOne. In the last Arbitrator Award, DSHS was given a "pass" on this issue because progress was being made on the acquisition of a modern payroll system through ProviderOne Phase 2. Without Phase 2 and PCS, there is a risk that the Arbitrator will dictate the solution and timing for implementing this requirement.

3. SAO and OIG Audit findings against ADSA are not corrected

   ADSA has received repeated audit findings from SAO due to the inability to capture time at the required quarter hour increments by date of service. ADSA also has an OIG finding related to clients/providers not having timesheets that show time by date of service. The corrective action plan for these findings is the implementation of ProviderOne Phase 2. With Phase 2, providers will be required to provide the hours worked for a client in quarter hour increments by date of service. The OIG audit identified $19.4M in disallowances. If DSHS does not correct the problem, OIG is recommending the state payback the $19.4M.

4. SSPS Must Remain Fully Operational and incorporate costly changes to address audit findings and SEIU requirements

   The most significant risks to SSPS are with development and operations staff. The SSPS technical team contains 11 developers and 1 manager. Of these 12, nine have relatively recent Unisys Cobol experience. Of these nine, eight are eligible to retire now. There are two mainframe database administrators, both are eligible to retire. Of the five SSPS Program Managers, three are eligible to retire. With the dying SSPS technology, it is very difficult to find people willing to fill these positions. There is a real risk that two-thirds of the SSPS development and maintenance staff could leave through retirement within the next several months leaving the state unable to properly maintain the system or enhance it to meet future requirements.

Additionally, the experienced team who implemented Phase 1 and are working on Phase 2 would be disbanded and momentum lost, making it unlikely that the state will ever succeed in consolidating Medicaid payment data into a single payment and decision support system.

What is the relationship, if any, to the state capital budget?
None.

What changes would be required to existing statutes, rules, or contracts, in order to implement the change?
No changes to existing statutes, rules, or contracts are required.

Expenditure and revenue calculations and assumptions.
Revenue Calculations and Assumptions:
Revenue assumes that the majority of costs for this project will qualify for 90 percent ffp.

Expenditure Calculations and Assumptions:

Vendor Services

The ProviderOne vendor, Client Network Services Incorporated (CNSI), will be responsible for the design, development and implementation of changes necessary to support Phase 2.

FTE Summary

The request for 31 FTEs in FY 2012 and 47 FTEs in FY 2013 includes the following:

			FY12 Salaries	FY12 Benefits		FY13 Salaries	FY13 Benefits
Project Mgmt & Support		**5**			**5**		
Admin	AA 4	1	42,000	16,000	1	42,000	16,000
Doc Control		1	60,000	19,000	1	60,000	19,000
Workplan Administrator	ITS 5	1	77,000	23,000	1	77,000	23,000
Legal	WMS - reports to Dir	1	80,000	24,000	1	80,000	24,000
Budget	WMS - Proj Staff	1	75,000	23,000	1	75,000	23,000
Functional and People Teams		**18**			**24**		
Functional Mgr	WMS - Proj Mgr	2	180,000	52,000	2	180,000	52,000
Business Analysts	WMS - Proj Staff	16	1,200,000	368,000	22	1,650,000	506,000
Technical Team		**8**			**8**		
Technical Mgr	WMS - Proj Mgr	1	90,000	26,000	1	90,000	26,000
Technical Analysts	ITS 5	7	588,000	175,000	7	588,000	175,000
Subtotal Project Team		**31**	**2,392,000**	**726,000**	**37**	**2,842,000**	**864,000**
OMSD (beginning 7/1/12)	ITS3				3	189,000	63,000
OMSD (beginning 1/1/13)	ITS3				2	63,000	21,000
Other (beginning 1/1/13)	(TBD; estimate ITS3)				12	378,000	126,000
Total		**31**	**2,392,000**	**726,000**	**47**	**3,472,000**	**1,074,000**

Category	#	Responsibility
Project Management & Support	5	Budget, work plan, legal, document control and administrative support
Functional Team	9	Design, configuration, and system expertise
Technical Team	8	Interfaces, data conversion and testing
Staff and Provider Readiness Team	15	Communication, outreach, business process re-engineering and training
Additional O&M Staff (17 positions; 3 beginning 7/12 and 14 beginning 1/13)	10	
Total	**47**	

Consulting Services Summary

Consulting services will be used for the following:

- Project Management
- Data Conversion and technical services
- Independent Verification and Validation (IV&V)
- Quality Assurance (QA)

	FY12	FY13
Personal Service Contracts (object C)		
Project Mgmt (OCG)	840,000	840,000
Data Conversion (Aetea)	255,000	255,000
QA (Sterling)	108,000	108,000
IV&V (SysTest)	126,000	126,000
Legal (DWT)	20,000	20,000
Consulting Technical (for PCS)	240,000	240,000
Consulting Technical	0	100,000
Total	1,589,000	1,689,000
Purchased Service Contracts (object E)		
CNSI - DDI		
Phase 2	883,000	1,341,000
Change Order Phase 2	$1,000,000	1,200,000
PCS	$2,614,000	3,500,000
Total	4,497,000	6,041,000

Which costs and functions are one-time? Which are ongoing? What are the budget impacts in future biennia?

Distinction between one-time and ongoing costs:
One-time costs for implementing Phase 2 are $23,853,000 ($2,401,000 GF-State) and ongoing costs for operations of the client hub are $617,000 ($179,000 GF-State). Ongoing operating costs for the vendor contract with CNSI will be negotiated in the upcoming year, but are assumed at the same level as the current annual cost plus $3,500,000 ($1,015,000 GF-State) annually for processing payments for individual providers represented by SEIU #775. The current CNSI contract expires 1/17/2013 and is currently being negotiated to address Phase 2.

Budget impacts in future biennia:
ProviderOne Phase 2 will be fully operational during the 2013-15 Biennium, following a three month pilot in a limited geographical region. HCA will prepare a request for the 2013-15 Biennium to address ongoing operational costs, including FTEs to address provider file maintenance, staff and provider security, provider customer service inquiries, imagining, and handling of paper claims. Experience during the pilot will refine performance and staffing levels for these areas. It is important to note that 90 percent (or 30,000) of the Phase 2 provider population are Individual Providers (IPs) represented by SEIU #775. This provider group has a high turnover rate where 1/3 of the group is replaced with new providers each year. Hence, there is an ongoing need for support and training for this population.